

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Fallon Senior Plan™ Retiree Group

January 1 – December 31, 2004

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Fallon Community Health Plan Customer Service:

For help or information, please call Customer Service Monday through Friday, 8 a.m. to 6 p.m. Calls to these numbers are free:

1-800-868-5200

TDD/TTY: 1-877-608-7677

Welcome to Fallon Senior Plan!™

We are pleased that you've chosen Fallon Senior Plan.™

Fallon Senior Plan™ is an HMO for people with Medicare

Now that you are enrolled in Fallon Senior Plan,™ you are getting your care through Fallon Community Health Plan. Fallon Senior Plan,™ an HMO, is offered by Fallon Community Health Plan. Fallon Senior Plan™ is *not* a “Medigap” or supplemental Medicare insurance policy.

This booklet explains how to get your Medicare services through Fallon Senior Plan™

This booklet, together with your enrollment form and any addenda, amendments or riders that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of Fallon Senior Plan.™ It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2004, through December 31, 2004.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of Fallon Senior Plan.™ This booklet gives you the details, including:

- What is covered in Fallon Senior Plan™ and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan and when you get care.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave Fallon Senior Plan,™ including your choices for continuing Medicare if you leave.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with Fallon Senior Plan.[™] If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

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How to contact Fallon Community Health Plan Customer Service

If you have any questions or concerns, please call or write to Fallon Community Health Plan Customer Service. We will be happy to help you. Our business hours are Monday through Friday, 8 a.m. to 6 p.m.

- CALL

1-800-868-5200. This number is also on the cover of this booklet for easy reference. Calls to this number are free.
- TDD/TTY

1-877-608-7677. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

Section 1. Telephone numbers and other information for reference

WRITE Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608

WEB SITE www.fchp.org

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for Centers for Medicare & Medicaid Services. The CMS contracts with and regulates Medicare Health Plans (including Fallon Community Health Plan and Medicare Private Fee-for-Service organizations).

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048 (you need special telephone equipment to use this number). Calls to these numbers are free.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information**. This website gives you a lot of up-to-date information about Medicare and nursing homes. It includes booklets you can print directly from your computer. It has a tool to help you compare Medicare managed care plans in your area. You can also search the “Helpful Contacts” section for the Medicare contacts in your

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state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

The Executive Office of Elder Affairs – an organization in Massachusetts that provides free Medicare help and information

The Executive Office of Elder Affairs is a state organization paid by the Federal Government to give free health insurance information and help to people with Medicare. The Executive Office of Elder Affairs has developed a program called SHINE (Serving Health Information Needs of Elders). The SHINE Program has trained counselors who can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. The SHINE Program has information about Medicare managed care plans and about Medigap (Medicare supplement insurance) policies. This includes information about special Medigap rights for people who have tried a Medicare+Choice plan (like Fallon Senior Plan™) for the first time. (Section 12 has more information about your Medigap guaranteed issue rights).

You can contact the Massachusetts Executive Office of Elder Affairs SHINE Program at:

Executive Office of Elder Affairs
Serving Health Information Needs of Elders (SHINE)
One Ashburton Place
Boston, MA 02108
Telephone: 1-800-882-2003 (TTY: 1-800-872-0166)

You can also visit the website for the Executive Office of Elder Affairs at www.800ageinfo.com.

Quality Improvement Organization – a group of doctors and health professionals in Massachusetts who review medical care and handle certain types of complaints from patients with Medicare

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In Massachusetts, the QIO is called Mass PRO. The doctors and other health experts in Mass PRO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. See Section 10 for more information about complaints.

You can contact Mass PRO at:

Mass PRO
235 Wyman St.
Waltham, MA 02451
Telephone: 1-800-334-6776 (TTY: 1-877-486-2048)

You can also visit the website for Mass PRO at www.masspro.org.

Other organizations (including Medicaid, Social Security Administration)

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some

Section 1. Telephone numbers and other information for reference

people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact:

Division of Medical Assistance
600 Washington St.
Boston, MA 02111
Telephone: 1-800-841-2900 (TTY: 1-800-497-4648)

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit www.ssa.gov on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number is 312-751-4701 (you need special telephone equipment to use this number). You can also visit www.rrb.gov on the web.

Employer (or “Group”) Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, your plan premiums, or the open enrollment season.

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What is Fallon Senior Plan™?

Now that you are enrolled in Fallon Senior Plan,™ you are getting your Medicare through Fallon Community Health Plan. Fallon Senior Plan™ is offered by Fallon Community Health Plan, and is an HMO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of Fallon Senior Plan.™ Fallon Senior Plan™ is **not** a Medicare supplement policy. (See Section 14 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called “Medigap” insurance policies.) Fallon Community Health Plan provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.


This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. Fallon Senior Plan™ gives you all of the usual Medicare services that are covered for everyone with Medicare. We also give you some additional services, such as eyeglasses and preventive dental care.

Since Fallon Senior Plan™ is a Medicare HMO, this means that you will be getting most or all of your health services from the doctors, hospitals, and other health providers that are part of Fallon Senior Plan.™ Since these doctors, hospitals, and other providers are the ones we are paying to provide your care, they are the ones you must use (except in special situations such as emergencies).


Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of Fallon Senior Plan,™ you have a Fallon Senior Plan™ membership card. Here is a sample card to show what it looks like:

Section 2. Getting the care you need, including some rules you must follow



FALLON COMMUNITY HEALTH PLAN
Fallon Senior Plan™



PHARMACYCARE

OVS

Rx \$

ER\$

INP\$

NAME

ID#

DB

HCO

BENEFITS

SEX

EMERGENCIES: In an emergency, go to the nearest emergency room for care or call 911. Afterwards, call us as soon as possible at the number below. For post-stabilization care, the treating hospital should call us immediately after stabilization for further care or to make other appropriate arrangements.

Important telephone numbers

Post stabilization care: 1-800-366-9113

Customer Service: 1-800-346-9113 TDD/TTY 1-877-606-7677

Behavioral Health Care: 1-800-421-8851 or TDD/TTY 1-781-994-7662

Rx Mail Order: 1-800-346-9113 or TDD/TTY 1-800-365-4155

Providers: RX Help Desk: 1-800-777-1023

Eligibility verification: 1-866-ASK-FCHP (1-866-275-3247)

Mail claim form to: Fallon Community Health Plan
PO Box 15121, Worcester, MA 01615

During the time you are a plan member and using plan services, **you must use your plan membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a member. If you get services using your red, white, and blue Medicare card instead of your Fallon Senior Plan™ membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your Fallon Senior Plan™ membership card with you at all times. You will need to show this card when you get covered services. You will also need it to get your prescriptions at the pharmacy. If your membership card is ever damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Help us keep your member records up to date

Fallon Community Health Plan has a file of information about you as a plan member. Doctors, hospitals, and other plan providers use these member records to know what services are covered for you. The member records have information from your enrollment form, including your address and telephone number. It shows your specific Fallon Senior Plan™ coverage and other information. Section 9 tells how we protect the privacy of your personal health information.

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 you must follow

Please help us keep your member records up to date by letting Customer Service know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse’s employer, workers’ compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident. See Section 1 for how to contact Customer Service.

What is the geographic service area for Fallon Senior Plan™?

The counties and parts of counties in our service area are listed below.

The Fallon Senior Plan™ service area includes all of Worcester County and parts of the following counties:

Franklin County, the following zip codes only:

Erving	01344	Warwick	01378
New Salem	01355	Wendell	01379
North New Salem	01364	Wendell Depot	01380
Orange	01364		

Hampden County, the following zip codes only:

Bondsville	01009	Palmer	01069
Brimfield	01010	Thorndike	01079
Holland	01521	Three Rivers	01080
Monson	01057	Wales	01081

Hampshire County, the following zip code only:

Ware	01082
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Section 2. Getting the care you need, including some rules you must follow

Middlesex County, the following zip codes only:

Acton	01720	Lowell	01851
Ashby	01431	Lowell	01852
Ashland	01721	Lowell	01853
Ayer	01432	Lowell	01854
Bedford	01730	Marlboro	01752
Billerica	01822	Maynard	01754
Billerica	01821	Natick	01760
Boxboro	01719	North Billerica	01862
Carlisle	01741	North Chelmsford	01863
Chelmsford	01824	Nutting Lake	01865
Concord	01742	Pepperell	01463
Dracut	01826	Pinehurst	01866
Dunstable	01827	Sherborn	01770
Framingham	01701	Shirley	01464
Framingham	01702	Shirley Center	01464
Framingham	01703	Stow	01775
Framingham	01704	Sudbury	01776
Framingham	01705	Tewksbury	01876
Groton	01450	Townsend	01469
Groton	01470	Tyngsboro	01879
Groton	01471	Village of	
Hanscomb AFB	01731	Nagog Woods	01718
Holliston	01746	Wayland	01778
Hopkinton	01748	West Groton	01472
Hudson	01749	West Townsend	01474
Littleton	01460	Westford	01886
Lowell	01850	Woodville	01784

Norfolk County, the following zip codes only:

Bellingham	02019	Norfolk	02056
Franklin	02038	Sheldonville	02070
Medway	02053	Wrentham	02093
Millis	02054		

Section 2. Getting the care you need, including some rules you must follow

Using plan providers to get services covered by Fallon Senior Plan™

You will be using plan providers to get your covered services

Now that you are a member of Fallon Senior Plan,™ with few exceptions, **you must use plan providers to get your covered services.**

- **What are “plan providers”?** “Providers” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “plan providers” when they participate in Fallon Senior Plan.™ When we say that plan providers “participate in Fallon Senior Plan,™” this means that we have arranged with them to coordinate or provide covered services to members of Fallon Senior Plan.™
- **What are “covered services”?** “Covered services” is the general term we use in this booklet to mean all of the health care services and supplies that are covered by Fallon Senior Plan.™ Covered services are listed in the Benefits Chart in Section 4.

As we explain below, you will have to choose one of our plan providers to be your PCP, which stands for Prietary Care Provider. Your PCP will provide or arrange for most or all of your covered services. Care or services you get from non-plan providers will not be covered, with few exceptions such as emergencies. (When we say “non-plan providers,” we mean providers that are not part of Fallon Senior Plan.™)

The Provider Directory gives you a list of plan providers

Every year as long as you are a member of Fallon Senior Plan™ we will send you a provider directory, which gives you a list of plan

Section 2. Getting the care you need, including some rules you must follow

providers. If you don't have the provider directory, you can get a copy from Customer Service (see Section 1 for how to contact Customer Service). You can ask Customer Service for more information about plan providers, including their qualifications and experience. Customer Service can give you the most up-to-date information about changes in plan providers and about which ones are accepting new patients.

Access to care and information from plan providers

You have the right to get timely access to plan providers and to all services covered by the plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 9 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing Your PCP (PCP means Primary Care Provider)

What is a "PCP"?

When you become a member of Fallon Senior Plan,TM you must choose a plan provider to be your PCP. Your PCP may be a physician, physician assistant or nurse practitioner that meets State requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

Section 2. Getting the care you need, including some rules you must follow

How do you choose a PCP?

You may choose a PCP by looking in the provider directory or by calling Customer Service for assistance. If there is a particular specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital. Once you have chosen a PCP you must notify Customer Service of your choice. You may change your PCP at any time.

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. As we explain below and in Section 4, there are only a few types of covered services you can get on your own, without contacting your PCP first.

Besides providing much of your care, your PCP will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care.

“Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will also need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP’s office. Section 9 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP’s office is closed?

What to do if you have a medical emergency or urgent need for care

Section 2. Getting the care you need, including some rules you must follow

In an emergency, you should get care immediately. You do **not** have to contact your PCP or get permission in an emergency. You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your PCP or get medical care when the PCP's office is closed, and it is not a medical emergency, call your PCP's telephone number. Plan providers' telephones are answered 24 hours a day, seven days a week. There will always be a plan provider on call to help you.

See Section 3 for more information about what to do if you have an urgent need for care.

Getting care from specialists

When your PCP thinks that you need specialized treatment, he or she will give you a referral (approval in advance) to see a plan specialist. A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). For some types of referrals to plan specialists, your PCP may need to get approval in advance from Fallon Community Health Plan's Health Management Services Department (this is called getting "prior authorization").

It is very important to get a referral from your PCP before you see a plan specialist (there are a few exceptions, including routine women's health care, that we explain later in this section). **If you don't have a referral before you receive services from a specialist, you may**

Section 2. Getting the care you need, including some rules you must follow

have to pay for these services yourself. If the specialist wants you to come back for more care, check first to be sure that the referral that you got from your PCP covers more visits to the specialist. In some instances, your PCP may give you a “standing referral” to a specialist. Standing referrals are valid for up to a maximum of 12 visits within a 12-month period. If the specialist feels you need additional specialty services the specialist will ask for authorization directly from the plan.

In some cases, your PCP may be affiliated with a medical group or network, which includes the specialists he or she uses for referrals. When you choose a PCP who belongs to a medical group or network, he or she is authorized by the plan to make referrals to specialists within that medical group or network. Check the provider directory “Physicians by Affiliation” section to find out if your PCP is part of a medical group or network. Referrals to specialists or referrals for services not available within the medical group or network require prior authorization from the plan.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. **This means that the Fallon Senior Plan™ specialists you can use may depend on which person you choose to be your PCP.** You can change your PCP at any time if you want to see a plan specialist that your current PCP cannot refer you to. Later in this section, under “Choosing your PCP,” we tell you how to change your PCP. If there are specific hospitals you want to use, find out whether the doctors you will be seeing use these hospitals.

Section 2. Getting the care you need, including some rules you must follow

There are some services you can get on your own, without a referral

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the covered services you get as a plan member. If you get services from any doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a plan provider. *But there are a few exceptions:* you can get the following services on your own, without a referral or approval in advance from your PCP. This is called “self-refer” when you get these services on your own. You still have to pay your copayment for these services.

- Routine women’s health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots, pneumonia and Hepatitis B vaccinations (as long as you get them from a plan provider).
- Routine dental care provided by a plan dentist.
- Routine eye exams with a plan optometrist or ophthalmologist.
- Mental health and substance abuse outpatient visits with a plan provider. This does not include partial hospitalization services.
- Emergency services, whether you get these services from plan providers or non-plan providers (see Section 3 for more information).
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan’s service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary

Section 2. Getting the care you need, including some rules you must follow

circumstances, the plan providers are temporarily unavailable or inaccessible. (See Section 3 for more information about urgently needed care. Earlier in this section, we explain the plan's service area.)

- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.

Getting care when you travel or are away from the plan's service area

If you need care when you are outside the service area, your coverage is very limited. The only services we cover when you are outside our service area are care for a medical emergency, urgently needed care, renal dialysis, and care that Fallon Community Health Plan or a plan provider has approved in advance. See Section 3 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Customer Service at the telephone number shown on the cover of this booklet.

How to change your PCP

You may change your PCP for any reason, at any time. To change your PCP, call Customer Service at the number shown on the cover of this booklet. When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will also check to

Section 2. Getting the care you need, including some rules you must follow

be sure the PCP you want to switch to is accepting new patients. Customer Service will change your member records to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

What if your doctor leaves Fallon Senior Plan?TM

Sometimes a PCP, specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of Fallon Senior Plan.TM If your PCP leaves Fallon Senior Plan,TM we will let you know, and help you switch to another PCP so that you can keep getting covered services.

SECTION 3 Getting care if you have a medical emergency or an urgent need for care

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What is a “medical emergency”?

A “medical emergency” is when you **reasonably believe that your health is in serious danger** — when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

Section 3. Getting care if you have a medical emergency or an urgent need for care

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do not need to get permission first from your PCP (primary care provider) or other plan provider.** (Section 2 tells about your PCP and plan providers.)
- Make sure that Fallon Senior Plan™ knows about your emergency, because we will need to be involved in following up on your emergency care. You or someone else should call Customer Service at the number shown on the cover of this booklet, to tell us about your emergency care as soon as possible, preferably within 48 hours.

Fallon Senior Plan™ will help manage and follow up on your emergency care

Fallon Senior Plan™ will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called “post-stabilization care.” Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world.
- Ambulance services are covered in situations where other means of transportation, anywhere in the world, would endanger your health.

Section 3. Getting care if you have a medical emergency or an urgent need for care

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care — thinking that your health is in serious danger— and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in “What is a ‘medical emergency’” above). However, please note that:

- If you get any additional care after the doctor says it was not a medical emergency, we will pay our portion of the covered additional care **if you get it from a plan provider**
- If you get any additional care from a *non-plan provider* after the doctor says it was not a medical emergency, we will usually not cover the additional care. There is an exception: we will pay our portion of the covered additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of “urgently needed care” that is given below.

What is “urgently needed care”? *(this is different from a medical emergency)*

“Urgently needed care” is **when you need medical attention right away for an unforeseen illness or injury**, and it is not reasonable given the situation for you to get medical care from your PCP or other plan providers. In these cases, your health is not in serious danger. As we explain below, how you get “urgently needed care” depends on whether you need it when you are in the plan’s service area, or outside the plan’s service area. Section 2 tells about the plan’s service area.

Section 3. Getting care if you have a medical emergency or an urgent need for care

What is the difference between a “ medical emergency” and “urgently needed care”?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. “Urgently needed care” is if you need medical help immediately, but your health is not in serious danger. A “medical emergency” is if you believe that your health is in serious danger.

Getting urgently needed care when you are in the plan’s service area

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan’s service area, please call your PCP. Plan providers’ telephones are answered 24 hours a day, seven days a week. There will always be a plan provider on call to help you. Keep in mind that if you have an urgent need for care while you are in the plan’s service area, we expect you to get this care from plan providers. In most cases, we will not pay for urgently needed care that you get from a non-plan provider while you are in the plan’s service area.

Getting urgently needed care when you are outside the plan’s service area

Fallon Senior Plan[™] covers urgently needed care that you get from non-plan providers when you are outside the plan’s service area. If you need urgent care while you are outside the plan’s service area, we prefer that you call your PCP first, whenever possible. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care through your PCP. However, we will cover follow-up care that you get from non-plan providers outside the plan’s service area as long as the care you are getting still meets the definition of “urgently needed care.”

Section 3. Getting care if you have a medical emergency or an urgent need for care

As explained in Section 2, we cover renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area (for up to six months in a row).

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What are “covered services”?

This section describes the medical benefits and coverage you get as a member of Fallon Senior Plan.™ **“Covered services,” means the medical care, services, supplies, and equipment that are covered by Fallon Senior Plan.™** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are not covered** (these are called “exclusions”). Section 5 also tells about **limitations** on certain services.

There are some conditions that apply in order to get covered services

Some general requirements apply to all covered services

The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 14 for a definition of “medically necessary.”)
- With few exceptions, covered services must either be provided by plan providers, be approved in advance by plan providers, or be authorized by Fallon Community Health Plan. The exceptions are care for a medical emergency, urgently needed care, and renal (kidney) dialysis you get when you are outside the plan’s service area.

In addition, some covered services require “prior authorization” in order to be covered

Some of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets “prior authorization” (approval in advance) from the Health Management Services Department at Fallon Community Health Plan. Covered services that need prior authorization are noted in the Benefits Chart.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits Chart – a list of covered services

Benefits chart – your covered services	What you must pay when you get these covered services
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INPATIENT SERVICES

Inpatient hospital care For more information about hospital care, see Section 7.

Inpatient hospital care requires prior authorization (approval in advance) from the plan to be covered.

You are covered for an unlimited number of days in an acute care hospital. This includes mental health and substance abuse services, but it does not include rehabilitation services.

You are covered for up to 100 days of care in each benefit period in an inpatient rehabilitation facility or rehabilitation unit of an acute care hospital. If you exceed the 100-day benefit period you may use your lifetime reserve days for additional coverage.

Covered services include, but are not limited to, the following:

- Semiprivate room (or a private room if medically necessary).
- Meals including special diets.

There is no copayment for inpatient hospital care; this includes medical, surgical, mental health, substance abuse and rehabilitation services.

If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital.

See Section 14 for an explanation of “benefit period”.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Inpatient hospital care, continued

- Regular nursing services.
- Costs of special care units (such as intensive or coronary care units).
- Drugs and medications.
- Lab tests.
- X-rays and other radiology services.
- Necessary surgical and medical supplies.
- Use of appliances, such as wheelchairs.
- Operating and recovery room costs.
- Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services.
- *Under certain conditions, the following types of transplants are covered: corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 7 for more information about transplants.*
- Blood – including storage and administration.
- Physician’s services.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Inpatient mental health care

<p>Includes mental health care services that require a hospital stay.</p> <p><i>Inpatient mental health care requires prior authorization (approval in advance) from the plan to be covered.</i></p> <p>You are covered for an unlimited number of days of inpatient mental health care in an acute care hospital.</p> <p>You are covered for up to 90 days in each benefit period for inpatient mental health care in a psychiatric hospital. There is a 190-day lifetime limit in a psychiatric hospital. You may use your lifetime reserve days for additional coverage once you have used the initial 90 days if you have not reached your 190-day lifetime limit. After you have reached the 190-day limit, the plan will guarantee payment for up to 60 days of care in a psychiatric hospital in each calendar year.</p>	<p>There is no copayment for inpatient mental health care.</p> <p>See Section 14 for an explanation of “benefit period”.</p>
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Skilled nursing facility care For more information about skilled nursing facility care, see Section 7.

<p><i>Skilled nursing facility care requires prior authorization (approval in advance) from the plan to be covered.</i></p>	<p>There is no copayment for skilled nursing facility care.</p>
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Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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**Skilled nursing facility care,
continued**

You are covered for up to 100 days in each benefit period in a skilled nursing facility. No prior hospital stay is required. Covered services include, but are not limited to, the following:

See Section 14 for an explanation of “benefit period”.

- Semiprivate room (or a private room if medically necessary).
- Meals, including special diets.
- Regular nursing services.
- Physical therapy, occupational therapy, and speech therapy.
- Drugs (this includes substances that are naturally present in the body, such as blood clotting factors).
- Blood—including storage and administration.
- Medical and surgical supplies.
- Laboratory tests.
- X-rays and other radiology services.
- Use of appliances such as wheelchairs.
- Physician’s services.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Inpatient services (when the hospital or SNF days are not or are no longer covered) For more information see Section 7.

Inpatient services (when the hospital or SNF days are not or are no longer covered) require prior authorization (approval in advance) from the plan to be covered.

- Physician services.
- Diagnostic tests (like X-ray or lab tests).
- X-ray, radium, and isotope therapy including technician materials and services.
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.
- Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.

There is no copayment for Medicare-covered inpatient services when the hospital or SNF days are not or are no longer covered.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Inpatient services (when the hospital or SNF days are not or are no longer covered), continued

- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.
 - Physical therapy, speech therapy, and occupational therapy.
-

Home health care For more information about home health care see Section 7.

Home health care requires prior authorization (approval in advance) from the plan to be covered.

There is no copayment for Medicare-covered home health care services.

Home Health Agency Care:

- Part-time or intermittent skilled nursing and home health aide services.
- Physical therapy, occupational therapy, and speech therapy.
- Medical social services.
- Medical equipment and supplies.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Hospice care For more information about hospice services see Section 7.

Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. Home care is also covered.

When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare (see Section 7 for more information about hospice services).

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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OUTPATIENT SERVICES

Physician services, including
doctor office visits

Some specialist visits and outpatient services, other than office visits to your PCP, require prior authorization (approval in advance) from the plan to be covered. For more information see Section 2.

- Office visits, including medical and surgical care in a physician’s office or certified ambulatory surgical center.
- Consultation, diagnosis, and treatment by a specialist.
- Second opinion by another plan provider prior to surgery.
- Outpatient hospital physician services.

You pay a \$10 copayment for each primary care office visit for Medicare-covered services.

You pay a \$10 copayment for each specialist office visit for Medicare-covered services.

There is no copayment for Medicare-covered ambulatory surgical center or outpatient hospital physician services

Chiropractic services

Chiropractic services require prior authorization (approval in advance) from the plan to be covered.

- Manual manipulation of the spine to correct subluxation.

You pay a \$10 copayment for each Medicare-covered visit for chiropractic services.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Podiatry services

Podiatry services require prior authorization (approval in advance) from the plan to be covered.

- Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).
- Routine foot care for members with certain medical conditions affecting the lower limbs.

You pay a \$10 copayment for each Medicare-covered visit for podiatry services.

Outpatient mental health care
(including partial hospitalization services)

Partial hospitalization services require prior authorization (approval in advance) from the plan to be covered.

Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws.

“Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor or therapist’s office and is an alternative to inpatient hospitalization.

You pay a \$10 copayment for each Medicare-covered visit for outpatient mental health care.

There is no copayment for partial hospitalization services.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Outpatient substance abuse services	You pay a \$10 copayment for each Medicare-covered visit for outpatient substance abuse services.
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Outpatient surgery	
<i>Outpatient surgery requires prior authorization (approval in advance) from the plan to be covered.</i>	There is no copayment for Medicare-covered outpatient surgery in an ambulatory surgical center, day surgery or hospital outpatient facility.
	You pay a \$10 copayment for each Medicare-covered visit to a physician’s office.

Ambulance services For more information on emergency ambulance services see Section 3.	
<i>Non-emergency ambulance requires prior authorization (approval in advance) from the plan to be covered.</i>	There is no copayment for Medicare-covered ambulance transport.

- Includes ambulance services dispatched through 911, where other means of transportation could endanger your health.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Emergency care For more information, see Section 3.

Coverage for emergency care is provided worldwide. See Section 14 for an explanation of “emergency care”.

You pay a \$50 copayment for each emergency room visit.

You do not pay the emergency room copayment if you are admitted to the hospital within 72 hours for the same condition.

If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital.

Observation room services
(following an emergency room visit)

Observation room services require prior authorization (approval in advance) from the plan to be covered.

You are covered for observation room services in a hospital setting when discharge is anticipated in 24 hours or less.

You pay the \$50 emergency room copayment for observation room services.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Urgently needed care For more information, see Section 3.

Urgently needed care is covered worldwide.	You pay a \$10 copayment for each urgently needed care visit.
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Outpatient rehabilitation services
(physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy)

Physical, occupational or speech and language therapy visits beyond the sixth visit require prior authorization (approval in advance) from the plan to be covered.

<ul style="list-style-type: none">• Physical, occupational and speech and language therapy.• Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	<p>You pay a \$10 copayment for each Medicare-covered physical, occupational or speech therapy visit.</p> <p>There is no copayment for Medicare-covered cardiac rehabilitation.</p>
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Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Durable medical equipment and related supplies

Durable medical equipment and related supplies require prior authorization (approval in advance) from the plan to be covered.

- Such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in Section 14.)
- Drugs you take using durable medical equipment (such as nebulizers) that are authorized by Fallon Community Health Plan.

There is no copayment for Medicare-covered durable medical equipment and related supplies (with the exception of prescription drugs).

For prescription drugs used with authorized durable medical equipment you pay:

- \$8 for Tier 1 drugs for up to a 30-day supply
- \$15 for Tier 2 drugs for up to a 30-day supply
- \$35 for Tier 3 drugs for up to a 30-day supply

Prosthetic devices and related supplies—(other than dental) which replace a body part or function.

Prosthetic devices and related supplies require prior authorization (approval in advance) from the plan to be covered.

There is no copayment for Medicare-covered prosthetic devices and related supplies.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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- Colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy).
 - Supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices.
 - Devices following cataract removal or cataract surgery – see “Vision Care” below.
-

Diabetes self-monitoring, training and supplies—for all people who have diabetes (insulin and non-insulin users).

Diabetes self-monitoring supplies require prior authorization (approval in advance) from the plan to be covered.

- Blood glucose meter, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.
 - One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts.
 - Self-management training is covered under certain conditions.
- There is no copayment for Medicare-covered diabetes self-monitoring, training and supplies.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
Medical nutrition therapy — for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	You pay a \$10 copayment for each Medicare-covered visit for medical nutrition therapy.

Outpatient diagnostic tests and therapeutic services and supplies

<ul style="list-style-type: none">• X-rays.• Outpatient radiation therapy.• Surgical supplies, such as dressings.• Supplies, such as splints and casts.• Laboratory tests.• Blood – including storage and administration.	<p>There is no copayment for Medicare-covered diagnostic tests and therapeutic services and supplies.</p> <p>\$10 office visit copayment applies</p>
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Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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PREVENTIVE CARE AND SCREENING TESTS
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Bone mass measurements

<i>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary:</i>	There is no copayment for Medicare-covered procedures to measure bone mass.
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- Procedures to identify bone mass, detect bone loss, or determine bone quality including a physician’s interpretation of the results.

Colorectal screening

<i>For people 50 and older, the following are covered:</i>	There is no copayment for colorectal screening procedures.
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- Fecal occult blood test, every 12 months, and
- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months, or
- Screening colonoscopy every 10 years, but not within 48 months of a screening flexible sigmoidoscopy.

\$10 office visit copayment applies.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Colorectal screening, continued

For people at high risk of colorectal cancer, the following are covered:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months.
-

Immunizations

Vaccines other than the pneumonia vaccine, flu shots and Hepatitis B vaccines, require prior authorization (approval in advance) from the plan to be covered.

- Pneumonia vaccine (as explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get the service from a plan provider).
- Flu shots, once a year in the fall or winter (as explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get the service from a plan provider).

There is no copayment for immunizations.
\$10 office visit copayment applies

Section 4. **Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™**

Benefits chart – your covered services	What you must pay when you get these covered services
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Immunizations, continued

- *If you are at high or intermediate risk of getting Hepatitis B:* Hepatitis B vaccine (as explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get the service from a plan provider).
 - Other vaccines if you are at risk.
-

Mammography screening As explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get it from a plan provider:

- One baseline exam between the ages of 35 and 39.
- One screening every 12 months for women age 40 and older.

There is no copayment for Medicare-covered mammography.

Pap smears, pelvic exams, and clinical breast exam As explained in Section 2, you can get these routine women’s health services on your own, without a referral from your PCP as long as you get the services from a plan provider:

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
<ul style="list-style-type: none">• For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 12 months.• <i>If you are at an increased risk of cancer, Pap tests, pelvic exams and clinical breast exams are covered more frequently when ordered by a plan provider.</i>	<p>There is no copayment for screening Pap tests, pelvic exams or clinical breast exams.</p> <p>\$10 office visit copayment applies</p>

Prostate cancer screening exams

<p><i>For men age 50 and older, the following are covered once every 12 months:</i></p> <ul style="list-style-type: none">• Digital rectal exam• Prostate Specific Antigen (PSA) test	<p>There is no copayment for Medicare-covered digital rectal exams or PSA tests.</p> <p>\$10 office visit copayment applies.</p>
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Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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OTHER SERVICES

Renal Dialysis (Kidney)

Home dialysis equipment and supplies require prior authorization (approval in advance) from the plan to be covered.

- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3).
- Inpatient dialysis treatments (if you are admitted to a hospital for special care).
- Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments).
- Home dialysis equipment and supplies.
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply).
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and Erythropoietin (Epogen®) or Epoetin alfa.

There is no copayment for Medicare-covered inpatient or outpatient dialysis.

There is no copayment for Medicare-covered training and support services

There is no copayment for Medicare-covered equipment or supplies used for home dialysis (with the exception of prescription drugs).

For prescription drugs used with authorized durable medical equipment you pay:

- \$8 for Tier 1 drugs for up to a 30-day supply
- \$15 for Tier 2 drugs for up to a 30-day supply
- \$35 for Tier 3 drugs for up to a 30-day supply

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Drugs that are covered under Original Medicare (these drugs are covered for everyone with Medicare)

“Drugs” includes substances that are naturally present in the body, such as blood clotting factors.

- Drugs that usually are not self-administered by the patient and are injected while receiving physician services.
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Fallon Community Health Plan.
- Clotting factors you give yourself by injection if you have hemophilia.
- Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
- Antigens.

There is no copayment for drugs administered by a health care professional.

\$10 office visit copayment applies

For prescription drugs covered under Original Medicare you pay:

Pharmacy:

–\$8 for Tier 1 drugs for up to a 30-day supply

–\$15 for Tier 2 drugs for up to a 30-day supply

–\$35 for Tier 3 drugs for up to a 30-day supply

Mail order:

–\$16 for Tier 1 drugs for up to a 90-day supply

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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**Drugs that are covered under
Original Medicare, continued**

<ul style="list-style-type: none">• Certain oral anti-cancer drugs and anti-nausea drugs.• Erythropoietin by self-injection if you have end-stage renal disease (permanent kidney failure); receive home dialysis; and need this drug to treat anemia.	<i>Mail order: continued</i> –\$30 for Tier 2 drugs for up to a 90-day supply –\$105 for Tier 3 drugs for up to a 90-day supply
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Coverage for outpatient prescription drugs is very limited. The drugs covered under Original Medicare are generally drugs that must be administered by a health professional. In addition to the drugs listed here that are covered under Original Medicare, Fallon Senior Plan™ offers an outpatient prescription drug benefit. This additional benefit is described below under the heading that says, “Fallon Senior Plan™ prescription drug benefit (outpatient prescription drugs)”.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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ADDITIONAL BENEFITS

Fallon Senior Plan™ prescription drug benefit (outpatient prescription drugs) “Drugs” includes substances that are naturally present in the body.

The Fallon Senior Plan™ prescription drug benefit covers the following:

- Certain outpatient prescription drugs. Section 6 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 6 also tells about drugs that are not covered by this benefit.

You pay copayments varying from \$8 to \$35 for each covered prescription, for up to a 30-day supply.

Section 6 tells you what you pay for outpatient prescription drugs and the rules you must follow to have your prescriptions covered.

Dental services As explained in Section 2, you can get these routine dental services on your own, without a referral from your PCP as long as you get the services from a plan provider:

- Preventive dental care including exam, cleaning, fluoride treatment and X-rays. Limited to once every six months.

You pay a \$10 copayment for each preventive dental visit.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Dental services, continued

<ul style="list-style-type: none">• Minor restorative dental care such as metal or composite fillings.• Out-of-area dental care: dental care for minor ailments such as a toothache or loose filling while you are out of the plan service area. Coverage is provided for up to \$50 per incident. <i>Go to the closest dentist and notify the plan as soon as possible.</i>• Emergency medical care such as to relieve pain or stop bleeding as a result of injury to the sound natural teeth or tissue, when provided as soon as medically possible after the injury. <i>Go to the closest provider and notify the plan as soon as possible. This does not include restorative or other dental care.</i>	<p>You pay copayments varying from \$16 to \$49 for minor restorative dental care. See your “Covered dental services” addendum for more information.</p> <p>You pay a \$10 copayment for out-of-area dental care.</p> <p>You pay a \$10 copayment for emergency medical care of the sound natural teeth or tissue.</p>
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Oral surgery services

<p><i>Oral surgery services, with the exception of the removal or exposure of impacted teeth, require prior authorization (approval in advance) from the plan to be covered.</i></p>	<p>You pay a \$10 copayment for each office visit for oral surgery services.</p>
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Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Oral surgery services, continued

- Surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor).
- Removal or exposure of impacted teeth, including hard and soft tissue impactions, or an evaluation for this procedure. (As explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get it from a plan provider.)
- Surgical treatments of cysts affecting the teeth or gums.
- Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed.

Hearing services

Diagnostic hearing exams require prior authorization (approval in advance) from the plan to be covered.

You pay a \$10 copayment for each Medicare-covered diagnostic hearing exam.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Hearing services, continued

- Diagnostic hearing exams.

Note: Routine hearing exams and hearing aids are not covered.

Vision care

Some procedures for the treatment of diseases or injuries of the eye require prior authorization (approval in advance) from the plan to be covered.

- Outpatient physician services for eye care.
- *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older:* glaucoma screening once every 12 months.
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Limited to designated designs.

You pay a \$10 copayment for each Medicare-covered office visit for eye care.

You pay \$10 for each routine eye exam.

There is no copayment for:

- eyeglasses or contact lenses following cataract surgery
- eyeglasses

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Vision care, continued

- Routine eye examinations, once in each 24-month period. (As explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get it from a plan provider.)
- One pair of eyeglasses (frames and lenses) in each 24-month period including measurement, fitting, adjustment and repair. Limited to designated designs.

Routine physical exams

You pay a \$10 copayment for each routine physical exam.

Infertility services

Infertility services require prior authorization (approval in advance) from the plan to be covered.

- Office visits for the diagnosis and treatment of infertility.
- Diagnostic laboratory and X-ray services.
- Artificial insemination

You pay a \$10 copayment for each office visit for the diagnosis and treatment of infertility.

There is no copayment for covered services in an ambulatory surgical center or hospital outpatient facility.

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Infertility services, continued

<ul style="list-style-type: none">• In vitro fertilization and embryo placement• Gamete intrafallopian transfer• Zygote intrafallopian transfer• Intracytoplasmic sperm injection• Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs.	There is no copayment for inpatient hospital services.
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Reconstructive surgery

<p><i>Reconstructive surgery requires prior authorization (approval in advance) from the plan to be covered.</i></p> <ul style="list-style-type: none">• Surgery for post-mastectomy patients for reconstruction of the breast on which the mastectomy was performed.• Surgery and reconstruction of the other breast to produce a symmetrical appearance• Treatment for any physical complications resulting from the mastectomy including lymphademas.	<p>You pay a \$10 copayment for each office visit for reconstructive surgery.</p> <p>There is no copayment for covered services in an ambulatory surgical center or hospital outpatient facility.</p> <p>There is no copayment for inpatient hospital services.</p>
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Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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Health and wellness education programs

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| <ul style="list-style-type: none">• SilverSneakers® Fitness Program—specialized classes focused on improving strength and flexibility, taught by certified SilverSneakers® fitness instructors, at participating area health clubs.• Weight Watchers®— members are eligible for one 12-consecutive week membership, including registration fee, in each calendar year.• <i>Healthy Communities</i>— published quarterly by Fallon Community Health Plan, our member magazine contains feature articles and information on plan sponsored events, classes and programs.• Fallon Foundation Lifetime Center—for those who want to take an active role in their health care, the Lifetime Center offers many health education and wellness programs, including nutrition, disease prevention, and support groups to help you cope with various illnesses. Fees for these programs, such as First Aid, CPR and T'ai Chi vary, many are provided at no cost. | <p>You pay:</p> <ul style="list-style-type: none">–\$0 for SilverSneakers®–\$0 for Weight Watchers®–\$0 for <i>Healthy Communities</i>–\$0 for smoking cessation classes–\$0 for osteoporosis support group–\$30 for First Aid–\$30 for CPR–\$65 for T'ai Chi |
|--|--|

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

Benefits chart – your covered services	What you must pay when you get these covered services
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**Health and wellness education
programs, continued**

- Senior Health Resource Line: 1-800-939-5433– provides information relating to seniors, including information on more than 3,500 senior assistance agencies, literature on special interest topics and wellness seminars.

For more information on any of these health and wellness education programs call Customer Service at 1-800-868-5200 (TTY: 1-877-607-7677).

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a member, we want to help. Please call Customer Service at the telephone number shown on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 10 for information about making a complaint.

Can your benefits change during the year?

The Medicare program has rules about when and how we can make changes in your benefits. **We can *increase* your benefits at any time during the calendar year** (the current calendar year is the period from January 1 through December 31, 2004). Here are some examples:

- If we decide to add a new benefit, this would be an increase in your benefits (even though you might have to pay something if you use the new benefit).
- If we decide to provide more of some benefit that you already have, this would be an increase in your benefits.
- If we decide to reduce the amount of a copayment, coinsurance, or plan premium, this would also be an increase in your benefits because you would be getting the same benefits for less money.

If we decide to increase any of your benefits during the calendar year, we will let you know in writing.

The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your

Section 4. Benefits chart—a list of the covered services you get as a member of Fallon Senior Plan™

benefits. We will tell you in advance (in October 2004) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2005.

At any time during the year, the Medicare program can change its national coverage.

Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. We would tell you in writing if anything changed in your coverage.

Can the prescription drugs that we cover change during the year?

The Medicare program allows us to make changes in our prescription drug formulary list at any time during the calendar year.

As we explain in Section 6, the formulary is a list of drugs. A change in our drug formulary list could affect how much you have to pay when you fill a covered prescription. Note that the formulary list applies only to the covered services listed in the Benefits Chart under the heading that says, “Fallon Senior Plan™ prescription drug benefit (outpatient prescription drugs).”

Section 5 Medical care and services that are NOT covered (list of exclusions and limitations)

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If you get services that are not covered, you must pay for them yourself58

What services are not covered by Fallon Senior Plan?™59

Introduction

The purpose of this section is to tell you about medical care and services that are not covered (“excluded”) or are limited by Fallon Senior Plan.™ The list below tells about these exclusions and limitations. The list describes services that are not covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 10 and 11).

Section 5. Medical care and services that are not covered (list of exclusions and limitations)

What services are not covered by Fallon Senior Plan?TM

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet, **the following items and services are not covered by Fallon Senior Plan:TM**

1. Services that are not covered under Original Medicare, unless such services are specifically listed as covered in Section 4.
2. Services that you get from non-plan providers, except for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-plan providers that is arranged or approved by a plan provider. See other parts of this booklet (especially Sections 2 and 3) for information about using plan providers and the exceptions that apply.
3. Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service.
4. Services that you get without prior authorization, when prior authorization is required for getting that service. (Section 4 gives a definition of prior authorization and tells which services require prior authorization.)
5. Services that are not reasonable and necessary under Original Medicare program standards. As noted in Section 4, we provide all covered services according to Medicare guidelines.
6. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information about getting care for a medical emergency).

Section 5. Medical care and services that are not covered (list of exclusions and limitations)

7. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Fallon Community Health Plan and Original Medicare to not be generally accepted by the medical community. See Section 7 for information about participation in clinical trials while you are a member of Fallon Senior Plan.TM
8. Surgical treatment of morbid obesity unless medically necessary and covered under Original Medicare.
9. Private room in a hospital, *unless* medically necessary.
10. Private duty nurses, *unless* medically necessary.
11. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
12. Nursing care on a full-time basis in your home.
13. Custodial care is not covered by Fallon Senior PlanTM *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. “Custodial care” includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
14. Homemaker services.
15. Charges imposed by immediate relatives or members of your household.
16. Meals delivered to your home.

Section 5. Medical care and services that are not covered (list of exclusions and limitations)

17. Unless medically necessary, elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.
18. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
19. Major restorative dental care, such as orthodontia, crowns, root canals, or dentures. Certain dental services that you get when you are in the hospital will be covered.
20. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in Section 4) and is limited according to Medicare guidelines.
21. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
22. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under “Outpatient Medical Services”).
23. Supportive devices for the feet. *There is an exception:* orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under “Outpatient Medical Services”).
24. Hearing aids and routine hearing examinations.

Section 5. Medical care and services that are not covered (list of exclusions and limitations)

25. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
26. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
27. Acupuncture.
28. Naturopaths' services.
29. Services provided to veterans in Veteran's Affairs (VA) facilities, unless the services are emergency services and the VA hospital is the closest facility.

Section 6 Prescription drugs (this section gives additional information about the outpatient prescription drug benefit that is listed in the Benefits Chart in Section 4)

Introduction to the Fallon Senior Plan™ outpatient prescription drug benefit64

With few exceptions, your prescriptions must be from plan providers and must be filled at a plan pharmacy or through our mail order service64

The Fallon Community Health Plan Prescription Drug Formulary list tells which drugs are covered by the prescription drug benefit64

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Filling your prescriptions at a plan pharmacy or through our mail order service69

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How to get help with questions or problems related to your prescription drug coverage72

Introduction to the Fallon Senior Plan™ outpatient prescription drug benefit

The purpose of this section is to give details about the Fallon Senior Plan™ outpatient prescription drug benefit. This benefit is listed in the Benefits Chart in Section 4 under the heading, “Fallon Senior Plan™ prescription drug benefit (outpatient prescription drugs).” This benefit covers certain drugs that require a prescription and that have been approved by the Food and Drug Administration (FDA).

With few exceptions, your prescriptions must be from plan providers and must be filled at a plan pharmacy or through our mail order service

In nearly all cases, your prescriptions are covered only if they are written or ordered by a plan doctor or other plan provider. In addition, as we explain later on, you must fill your prescriptions at certain pharmacies or through our own mail order pharmacy service. There is an exception for medical emergencies and urgently needed care. If it is a medical emergency or urgently needed care, we cover prescriptions you get from doctors who are not plan providers and prescriptions that are filled at non-plan pharmacies. Section 3 tells about care for a medical emergency and urgently needed care.

The Fallon Community Health Plan Prescription Drug Formulary list tells which drugs are covered by the prescription drug benefit

The Fallon Community Health Plan Prescription Drug Formulary is a list of prescription drugs that plan doctors refer to when they need to prescribe drugs. Often they prescribe drugs that are included on the Fallon Community Health Plan Prescription Drug Formulary list, but sometimes they prescribe drugs that are not on the list.

Section 6. Prescription drugs

As we explain a little later, **in nearly all cases, your prescriptions are covered only if the drug is included on the Fallon Community Health Plan Prescription Drug Formulary list.**

The Fallon Community Health Plan Prescription Drug Formulary list was created by a group of doctors and pharmacists. They picked the drugs that are on the Fallon Community Health Plan Prescription Drug Formulary list **based on how safe and effective they are, and how much they cost.** We call the drugs that are on this list “formulary drugs.” We call drugs that are *not* on the list “non-formulary drugs.” The Fallon Community Health Plan Prescription Drug Formulary list has a three-tiered copayment structure. There is a different copayment for each tier. Tier 1 includes most generic drugs and has the lowest copayment. Tier 2 has the next lowest copayment and includes brand-name drugs and the higher cost generic drugs. Tier 3 drugs have the highest copayment. Tier 3 contains brand-name drugs with generic equivalents, higher-cost brand name drugs, some higher-cost generic drugs and drugs that are newly approved by the FDA. **To get a copy of the Fallon Community Health Plan Prescription Drug Formulary list,** call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) Monday through Friday, 8 a.m. to 6 p.m. The Fallon Community Health Plan Prescription Drug Formulary list is also available on the Fallon Community Health Plan website on the Internet at www.fchp.org.

The Fallon Community Health Plan Prescription Drug Formulary list includes selected brand-name and generic drugs

- **Brand-name drugs** are drugs that are produced and sold under the original manufacturer’s brand name.
- **Generic drugs** are produced and sold under their chemical names, rather than under the names of the companies that manufacture them. A generic drug is a lower cost version of a brand name drug. Some brand-name drugs have a generic equivalent and others do not.

Section 6. Prescription drugs

Generic drugs generally cost less, **but generic and brand-name drugs are the same in terms of quality and how they work.** The law requires that a generic drug must contain the same amount of the same active drug ingredient as the brand-name drug. However, a generic drug may differ in certain other ways, such as its color or its flavor, the shape of the pill or tablet, and the inactive (non-drug) ingredients it contains.

As we explain below, you pay less for formulary drugs if you get a generic drug rather than a brand-name drug. The Fallon Community Health Plan Prescription Drug Formulary list includes most generic drugs. Fallon Senior Plan's™ plan pharmacies and mail order service fill prescriptions using generic drugs rather than brand-name drugs whenever possible.

How much do you pay when you fill a prescription?

The amount you pay when you fill a covered prescription is called your **copayment**. Your copayment can vary from \$8 to \$35 for up to a 30-day supply (depending on the drug) when you get your prescription filled at a plan pharmacy.

- When you fill a prescription, you pay either the copayment listed below, or you pay the full cost of the prescription – whichever is *lower*.
- **There is a limit on how much of the drug you can get for one copayment.** For most oral medications, such as pills or other drugs that you swallow, the maximum is a 30-day supply (or less than a 30-day supply for one copayment if your doctor orders less). For medications other than ones you swallow, the maximum depends on the type of medication. The maximum amount per copayment might be a single container, inhaler unit, package, or course of therapy. For example, you would have to pay two

Section 6. Prescription drugs

copayments if you got two inhalers. If your doctor prescribes an amount of medication that is smaller than the maximum allowed for a single copayment, you must still pay the full copayment.

- If you fill the prescription through our mail order service, you pay \$16 for up to a 90-day supply of Tier 1 drugs, \$30 for up to a 90-day supply of Tier 2 drugs, or \$105 for up to a 90-day supply of Tier 3 drugs.

For drugs that are included on the Fallon Community Health Plan Prescription Drug Formulary list, here are your copayments:

- **\$8 for a Tier 1 drug** if you get it at a plan pharmacy, for up to a 30-day supply or less, depending on how your doctor orders it. If the drug is available and you order it through our mail order service the copayment is **\$16** for up to a 90-day supply.
- **\$15 for a Tier 2 drug** if you get it at a plan pharmacy, for up to a 30-day supply or less, depending on how your doctor orders it. If the drug is available and you order it through our mail order service the copayment is **\$30** for up to a 90-day supply.
- **\$35 for a Tier 3 drug** if you get it at a plan pharmacy, for up to a 30-day supply or less, depending on how your doctor orders it. If the drug is available and you order it through our mail order service the copayment is **\$105** for up to a 90-day supply.

Important things to know about Fallon Community Health Plan Prescription Drug Formulary list and how much you pay

In nearly all cases, a drug must be on the Fallon Community Health Plan Prescription Drug Formulary list in order to be covered

The outpatient prescription drug benefit covers the drugs that are on the Fallon Community Health Plan Prescription Drug

Section 6. Prescription drugs

Formulary list. We make exceptions only under special circumstances. For example, there may be medical reasons why a non-formulary drug is needed in place of a formulary drug. In this situation, your doctor must get approval in advance (this is called “prior authorization”) from Fallon Community Health Plan’s Pharmacy Services Department in order for the non-formulary drug to be covered. Requests for coverage are reviewed and decisions are made based on medical necessity. If a request for coverage of a non-formulary drug is approved it will be assigned to Tier 3 and the copayment will be \$35 for up to a 30-day supply. If we deny a request for an exception, you have a right to appeal that request (see Section 10 for more information on appeals).

Some formulary drugs are covered only if your doctor gets approval in advance to prescribe them

Some of the drugs included in the prescription drug benefit are covered only if your doctor calls and gets approval in advance from Fallon Community Health Plan’s Pharmacy Services Department before prescribing the drug (this is called “prior authorization”). Prior authorization is typically required for drugs that are very expensive. The drugs that require prior authorization are marked on the Fallon Community Health Plan Prescription Drug Formulary list.

Since the Fallon Community Health Plan Prescription Drug Formulary list can change during the year, there could be changes in the drugs available to you or in what you have to pay for a particular drug

A committee of doctors and pharmacists reviews and updates the Fallon Community Health Plan Prescription Drug Formulary list regularly throughout the year. This means that drugs can be added to or dropped from the Fallon Community Health Plan Prescription Drug Formulary list at any time without notice. Drugs may also change FDA status from a prescription drug to an over-the-counter

Section 6. Prescription drugs

drug. Drugs can also be changed from one Tier of drugs to another within the formulary. Changes in the Fallon Community Health Plan Prescription Drug Formulary list can affect which drugs are covered for you and the amount of your copayment when you fill a prescription. If your doctor feels it is medically necessary to continue prescribing a drug you have been taking that is no longer available on the Fallon Community Health Plan Prescription Drug Formulary list, your doctor can ask Fallon Community Health Plan to authorize an “exception” for you so that you can continue to receive prescription coverage for that specific drug. If Fallon Community Health Plan authorizes an exception, the drug will be assigned to Tier 3 and the copayment will be \$35 for up to a 30-day supply. You can call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) Monday through Friday, 8 a.m. to 6 p.m. to find out if your drug is on the Fallon Community Health Plan Prescription Drug Formulary list or you can look on the Fallon Community Health Plan website on the Internet at www.fchp.org.

Filling your prescriptions at a plan pharmacy or through our mail order service

Filling prescriptions at a plan pharmacy

To get a list of the pharmacies you can use look in your provider directory. If you need a provider directory, call Customer Service. We call the pharmacies on this list our “plan pharmacies” because we have made arrangements with them to handle prescriptions for members of Fallon Senior Plan.[™]

To use your prescription drug benefit, you must show your Fallon Senior Plan[™] membership card at one of our plan pharmacies. If you do not have your membership card with you when you fill the prescription, you will have to pay the *full cost* of the prescription (rather than paying just your copayment). If this happens to you, you

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can ask us to reimburse you for our share of the cost by sending us a copy of your pharmacy receipt. For more information call Customer Service at the number listed on the cover of this booklet.

If you are a new member and need to have an existing prescription refilled, remember that the prescription must be written by plan provider or it will not be covered (even if you fill it at a plan pharmacy). You should consult with your current doctor to see if he or she wants you to continue on the medication, and you must get a new prescription from your current doctor.

Using the mail order pharmacy service

To get order forms and information about filling your prescriptions by mail, call Customer Service. Please note that you must use the mail order service affiliated with the plan. Prescription drugs that you get at any other mail order service are not covered.

You can use the mail order service to fill prescriptions for any drug that can be safely mailed. Most drugs can be mailed, however, there are some that cannot. Also, some diabetic supplies cannot be mailed. The pharmacist will make the determination.

When you order prescription drugs by mail, you may order up to a 90-day supply.

Things to know about getting your prescriptions filled

If you fill your prescription at a pharmacy that is not a plan pharmacy, you will have to pay the full cost of the prescription yourself, and we will not pay for any part of the cost. There is an exception: prescriptions filled at a non-plan pharmacy are covered if they are related to care for a medical emergency or urgently needed care. In this situation, you can ask us to pay our share of the cost by sending us a copy of the pharmacy receipt within 180 days.

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If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. If you plan to be away for three months or less, you may be able to order your prescription drugs ahead of time through the mail order pharmacy, or refill your prescriptions at a plan pharmacy away from home. To find out if there is a plan pharmacy in the area you will be visiting, call Customer Service at the number listed on the cover of this booklet. There is no out-of-service-area benefit for prescription drugs (Section 2 tells you about our service area). Drugs you get from non-plan pharmacies while out of our service area will not be covered, regardless of the circumstances, unless they are part of care for a medical emergency or urgently needed care (care for a medical emergency and urgently needed care are discussed in Section 3).

Prescription drug benefit exclusions (drugs that are not covered)

The following list shows which types of drugs or categories of drugs are not covered. These are called “exclusions.” Also, see Section 4 (Benefits chart – a list of the covered services you get as a plan member), Section 5 (“Medical care and services that are not covered – a list of exclusions”), and the Fallon Community Health Plan Prescription Drug Formulary list for more information about drugs that are not covered.

- Drugs that you can buy without a prescription.
- Drugs that are investigational or that have not been approved for sale and distribution by the FDA.
- Drugs for purposes that are not medically necessary. This includes but is not limited to drugs for cosmetic purposes, to enhance athletic performance, for appetite suppression, or for other noncovered conditions.

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- Vitamins and minerals, whether or not a prescription is required.
- Devices for birth control.

How to get help with questions or problems related to your prescription drug coverage

To learn more about your prescription drug benefits or if you have any problems or concerns related to using your prescription drug coverage, please call Customer Service at 1-800-868-5200 (TTY/TDD: 1-877-608-7677) Monday through Friday, 8 a.m. to 6 p.m.

From time to time, Fallon Community Health Plan may make decisions that affect your prescription drug coverage, such as whether a particular drug is covered for you, or whether we approve your doctor's request for an exception to the usual rules about prescription drug coverage. If you are unhappy about a decision we make about whether a prescription is covered, or the amount of payment for a prescription, you have the right to make an appeal (an appeal asks us to reconsider and change our decision about coverage or payment). If you want to make any *other* types of complaints related to your prescription drug benefit, you would file a "grievance." Section 10 discusses grievances and appeals. You can also call Customer Service to get additional information or help with a grievance or appeal.

SECTION 7

Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 4)

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Hospital care

If you need hospital care, we will arrange covered services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading “Inpatient Hospital Care.” We use “hospital” to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term “hospital” does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By “custodial care,” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

Section 7. Hospital care, skilled nursing facility care, and other services

In most cases, your primary care provider will determine which hospital you are admitted to based on his or her admitting privileges. For a listing of the hospitals your primary care provider admits patients to, look in your provider directory or call Customer Service for assistance.

What is a “benefit period” for hospital care?

Fallon Senior Plan[™] uses benefit periods to determine your coverage for inpatient rehabilitation services in either a rehabilitation hospital or the rehabilitation unit of an acute care hospital, if you are an inpatient in a psychiatric hospital, or if you are an inpatient in a skilled nursing facility. A **“benefit period”** begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. (Later in this section we explain about SNF services).

Please note that after your hospital day limits are used up, we will still pay for covered physician services and other medical services. These services are listed in the Benefits Chart in Section 4 under the heading, “Inpatient services (when the hospital or SNF days are not or are no longer covered).”

What happens if you join or drop out of Fallon Senior Plan[™] during a hospital stay?

If you either join or leave Fallon Senior Plan[™] during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Customer Service at the telephone number shown on the cover of this booklet. Customer Service can explain how your services are covered for this stay, for the periods of your stay when you were and were not a plan member.

Section 7. Hospital care, skilled nursing facility care, and other services

What is a “hospitalist”?

When you are admitted to a hospital, your PCP might ask a “hospitalist” to handle your care. A hospitalist is a doctor who specializes in caring for patients who are in a hospital. The hospitalist usually has an office in the hospital and focuses on caring for conditions that are usually treated in a hospital, such as heart or lung disease. The hospitalist will work with Fallon Senior Plan™ to coordinate your care while you are in the hospital. When you leave the hospital, your PCP will resume caring for you. Medicare has published a booklet, “What kind of doctor is a hospitalist?” It is available at the Medicare website, www.medicare.gov.

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading “Skilled nursing facility care.” The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is a **place that provides skilled nursing or skilled rehabilitation services**. It can be a separate facility, or part of a hospital or other health care facility. A skilled nursing facility is called a “SNF” for short. The term “skilled nursing facility” does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By “custodial care,” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

What is skilled nursing facility care?

“Skilled nursing facility care” means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation

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services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

“Custodial care” is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Fallon Senior Plan™ unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A “benefit period” begins on the first day you go to a

Section 7. Hospital care, skilled nursing facility care, and other services

Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. As shown in the Benefits Chart in Section 4, you must pay a copayment for each inpatient admission to a skilled nursing facility.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, “Inpatient services (when the hospital or SNF days are not or are no longer covered).”

In some situations, you may be able to get care in a SNF that is not a plan provider

Generally, you will get your skilled nursing facility care from SNFs that are plan providers for Fallon Senior Plan.™ However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a plan provider. One of the conditions is that the SNF that is not a plan provider must be willing to accept Fallon Senior Plan’s™ rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a “Home SNF”):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

Section 7. Hospital care, skilled nursing facility care, and other services

Home health care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading “Home health care.” If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health services?

To get home health care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are on infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated.

“Supportive devices” include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

Section 7. Hospital care, skilled nursing facility care, and other services

2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.
4. **You must need *at least one* of the following types of skilled care:**
 - Skilled nursing care on an “intermittent” (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
 - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
 - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
 - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

If you meet all four of these conditions for getting home health care, Fallon Senior Plan[™] covers either part-time or intermittent home health care services. As explained below, this means that there are limits on the number of hours per day and days per week that you can get home health services.

Section 7. Hospital care, skilled nursing facility care, and other services

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are “part time” and “intermittent” home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for “part time” or “intermittent” skilled nursing services and home health aide services:

- **“Part-time” or “Intermittent”** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

“Hospice” is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

Section 7. Hospital care, skilled nursing facility care, and other services

As a member of Fallon Senior Plan,[™] you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Customer Service at the number on the cover of this booklet to get a list of the Medicare-certified hospice providers in your area. (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Customer Service to get information on your hospice coverage.)

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Fallon Senior Plan[™]) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through Fallon Senior Plan.[™]

The Medicare program has written a booklet about “Medicare Hospice Benefits.” To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please

Section 7. Hospital care, skilled nursing facility care, and other services

be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not Fallon Senior Plan™) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in Fallon Senior Plan™ and continue to get the rest of your care that is unrelated to the clinical trial through Fallon Senior Plan.™ You will have to pay the Original Medicare coinsurance for the clinical trial services.

The Medicare program has written a booklet about “Medicare and Clinical Trials.” To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare’s website.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by Fallon Senior Plan[™] under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of “nonexcepted” medical treatment. (“Excepted” medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. “Nonexcepted” medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Fallon Senior Plan,[™] or your stay in the RNHCI may not be covered.

SECTION 8

What you must pay for your Medicare health plan coverage and for the care you receive

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Paying the plan premium for your coverage as a member of Fallon Senior Plan™

To be a member of Fallon Senior Plan,™ you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member.

Section 8. What you must pay for your Medicare health plan coverage and for the care you receive

As a Fallon Senior Plan™ member enrolled through an employer group your plan sponsor pays the plan premium to Fallon Senior Plan™ for your coverage

We will send the bill for the plan premium to your plan sponsor for payment. Your plan sponsor then pays the premium to Fallon Senior Plan™ on your behalf. Fallon Senior Plan™ is not responsible if your plan sponsor fails to pay the premium. This is true even if you have paid all or part of the premium to your plan sponsor. You can obtain information on the plan premium from your plan sponsor or you can call Customer Service at the telephone number on the cover of this booklet.

Paying your share of the cost when you get covered services

What are “copayments”?

A “copayment” is a payment you make for your share of the cost of certain covered services you receive. A copayment is a **set amount per service** (such as paying \$10 for a doctor visit). You pay it when you get the service. The Benefits Chart in Section 4 gives your copayments for covered services.

What is the most you will pay for covered care?

There is a limit to how much you will have to pay for your Medicare-covered health care each year. During the year, if the amount that you spend on your copayments as a member of Fallon Senior Plan™ goes over \$2,560, we will begin to pay for all of your Medicare-covered health care.

Section 8. What you must pay for your Medicare health plan coverage and for the care you receive

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by Fallon Senior Plan.[™] Other sections of this booklet tell about covered services and the rules that apply to getting your care as a plan member. With few exceptions, you must pay for services you receive from providers who are not part of Fallon Senior Plan[™] unless Fallon Community Health Plan has approved these services in advance. The exceptions are care for a medical emergency, urgently needed care, out-of-area renal (kidney) dialysis services, and services that are found upon appeal to be services that we should have paid or covered. (Sections 2 and 3 explain about using plan providers and the exceptions that apply.)

For covered services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service.** For example, you have to pay the full cost for room and board in a skilled nursing facility if your stay exceeds 100 days in a benefit period. (Medicare covers some inpatient services when the inpatient days are not or are no longer covered. For more information, see Section 7.) You can call Customer Service when you want to know how much of your benefit limit you have already used.

Please keep us up-to-date on any other health insurance coverage you have

Using all of your insurance coverage

If you have other health insurance coverage besides Fallon Senior Plan,[™] it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is called “coordination of benefits” because it involves *coordinating* all of

Section 8. What you must pay for your Medicare health plan coverage and for the care you receive

the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides Fallon Senior Plan,[™] and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "Tricare for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Section 8. What you must pay for your Medicare health plan coverage and for the care you receive

Who pays first when you have additional insurance?

When you have additional insurance coverage, how we coordinate your benefits as a member of Fallon Senior Plan™ with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through Fallon Senior Plan,™ and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by Fallon Senior Plan,™ you may get your care outside of Fallon Senior Plan.™

In general, the insurance company that pays its share of your bills *first* is called the **“primary payer.”** Then the other company or companies that are involved—called the **“secondary payers”**—each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second—or at all—depends on what type or types of additional insurance you have and the rules that apply to your situation.** Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer’s group insurance.

If you have additional health insurance, please call Customer Service at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It’s called *Medicare and Other Health Benefits: Your Guide to Who Pays First*. You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov website.

Section 8. What you must pay for your Medicare health plan coverage and for the care you receive

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Sections 2 and 3, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the plan's service area, care that has been approved in advance by Fallon Community Health Plan, and services that we denied but that were overturned in an appeal. If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at Fallon Community Health Plan, Claims Department, P.O. Box 15121, Worcester, MA 01615-0121. It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-plan provider any more than what he or she would have received from you if you had been covered with Original Medicare.

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Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 9, we explain your Medicare rights and protections as a member of Fallon Senior Plan.™ Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048).

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Fallon Community Health Plan must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Customer Service at the number on the cover of this booklet. Customer Service can also help if you need to file a complaint about access (such as wheel chair access).

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission

Section 9. Your rights and responsibilities as a member of Fallon Senior Plan™

from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service at the phone number on the cover of this booklet.

Your right to see plan providers and get covered services within a reasonable period of time

As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of Fallon Senior Plan.™ You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get

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appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by Fallon Senior Plan.™ You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a plan provider has denied care that you believe you are entitled to receive. In these cases, you must request an initial decision. “Initial decisions” are discussed in Section 11.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves

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due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called **“advance directives.”** There are different types of advance directives and different names for them. Documents called **“living will”** and **“power of attorney for health care”** are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, from some office supply stores or by calling Customer Service at the telephone number on the cover of this booklet. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as the Executive Office of Elder Affairs. Section 1 of this booklet tells how to contact the Executive Office of Elder Affairs. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the Commonwealth of Massachusetts, Department of Public Health, 250 Washington Street, Boston, MA 02108.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make. Which one you make depends on your situation. Appeals are discussed in Sections 10 and 11, and grievances are discussed in Section 10.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against Fallon Community Health Plan in the past. To get this information, call Customer Service at the phone number on the cover of this booklet.

Your right to make recommendations regarding Fallon Senior Plan’s™ members’ rights and responsibilities policies

You have the right to make recommendations to us about Fallon Senior Plan’s™ members’ rights and responsibilities policies. If you have a recommendation please call Customer Service at the telephone number on the cover of this booklet.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay. If you need more information, please call Customer Service at the number on the cover of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by Fallon Senior Plan.™ We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 10 and 11 for more information about filing an appeal.

Your right to get information about Fallon Community Health Plan, Fallon Senior Plan™ and plan providers

You have the right to get information from us about Fallon Community Health Plan and Fallon Senior Plan.™ This includes information about our financial condition, about our health care providers and their qualifications, and about how Fallon Senior Plan™ compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Customer Service at the phone number on the cover of this booklet.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Service at the number on the cover of this booklet. You can also get free help and information from the Executive Office of Elder Affairs (Section 1 tells how to contact the Executive Office of Elder Affairs). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To

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get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Or you can visit the Medicare website at www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights at 1-617-223-9662 (TDD/TTY: 1-617-223-9695).
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Customer Service at the number on the cover of this booklet. You can also get help from the Executive Office of Elder Affairs (Section 1 tells how to contact the Executive Office of Elder Affairs).

What are your responsibilities as a member of Fallon Senior Plan?™

Along with the rights you have as a member of Fallon Senior Plan,™ you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you such as addenda, amendments, or riders

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to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service at the phone number on the cover of this booklet if you have any questions.

- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions.
- To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay your plan premiums and any copayments you may owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 8 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service at the phone number on the cover of this booklet.

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Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call Customer Service at the number on the cover of this booklet.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if

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you have concerns or problems with any part of your medical care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from Fallon Senior Plan™ or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make.

- An **“appeal”** is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service.** For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If Fallon Community Health Plan or one of our plan providers refuses to give you a service you think should be covered, you can file an appeal. If Fallon Community Health Plan or one of our plan providers reduces or cuts back on services you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service too soon, you can file an appeal.
- A **“grievance”** is the type of complaint you make **if you have any other type of problem with Fallon Community Health Plan, Fallon Senior Plan,™ or one of our plan providers.** For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor’s office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

1. **Making complaints (called “appeals”) about what we will cover for you or what we will pay for.** If Fallon Community Health Plan or your doctor or another plan provider has refused to give you a service you think is covered, you can make an appeal. If we have refused to pay for a service you think is covered for you, you can make an appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).
2. **Making complaints (called “appeals”) if you think you are being discharged from the hospital too soon.** There is a special type of appeal that applies only to hospital discharges. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to Mass PRO, which is the Quality Improvement Organization (QIO) in the state of Massachusetts. Mass PRO is a group of health professionals Massachusetts that is paid to handle this type of appeal from Medicare patients. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.
3. **Making complaints (called “appeals”) if you think your coverage for SNF, home health or certified outpatient rehabilitation facility services is ending too soon.** There is another special type of appeal that applies only to when coverage

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will end for SNF, home health or certified outpatient rehabilitation facility services. If you think your coverage is ending too soon, you can appeal directly and immediately to Mass PRO, which is the Quality Improvement Organization in the state of Massachusetts] If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

4. **Making complaints (called “grievances”) about any other type of problem you have with Fallon Community Health Plan, Fallon Senior Plan™ or one of our plan providers.** If you want to make a complaint about any type of problem other than the two that are listed above, a grievance is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor’s office. Generally, you would file the grievance with Fallon Community Health Plan. But for many problems related to quality of care you get from plan providers, you can also complain to the QIO in your state.

PART 1. Making complaints (called “appeals”) to Fallon Community Health Plan to change a decision about what we will cover for you or what we will pay for

This part of Section 10 explains what you can do if you have problems getting the medical care you believe we should provide. We use the word “provide” in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or

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continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by Fallon Senior Plan.TM
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Fallon Senior Plan.TM
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by Fallon Senior PlanTM while you were a member, but we have refused to pay for this care.

Six possible steps for requesting care or payment from Fallon Senior PlanTM

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

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The six possible steps are summarized below (they are covered in more detail in Section 11).

STEP 1: The initial decision by Fallon Community Health Plan

The starting point is when we make an “initial decision” (also called an “organization determination”) about your medical care or about paying for care you have already received. When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of Fallon Senior Plan™ apply to your specific situation. As explained in Section 11, you can ask for a “fast initial decision” if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by Fallon Community Health Plan

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an “**appeal**” or a “request for reconsideration.” As explained in Section 11, you can ask for a “fast appeal” if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of Fallon Community Health Plan. This organization will review your request and make a decision about whether we must give you the care or payment you want.

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STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least \$100 to be considered in Step 4.

STEP 5: Review by a Departmental Appeals Board

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a **Departmental Appeals Board** to review your case. This Board is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the Departmental Appeals Board in Step 5, either of us may be able to take your case to a Federal Court. The dollar value of your contested medical care must be at least \$1,000 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, see Section 11.

PART 2. Making complaints if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by Fallon Senior Plan™ that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your “discharge date”) is based on when your stay in the hospital is no longer medically necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

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Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.

Review of your hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, you must ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights*. This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, be sure to ask for it immediately.

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You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the “Quality Improvement Organization”?

“QIO” stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Fallon Community Health Plan or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Massachusetts, the QIO is called Mass PRO. The doctors and other health experts in Mass PRO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. *The Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a **“fast review”** of whether you are ready to leave the hospital. This “fast review” is also called a “fast appeal” because you are appealing the discharge date that has been set for you.
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are

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allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the QIO gives you its decision.
- If the QIO agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking Fallon Community Health Plan for a “fast appeal” of your discharge

If you do not ask the QIO for a “fast review” (“fast appeal”) of your discharge by the deadline, you can ask us for a “fast appeal” of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

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- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, then we will **not** cover any hospital care you received if you stayed in the hospital after the discharge date.

You may have to pay if you stay past your discharge date

If you do not ask the QIO by noon of the next working day after you are given written notice that you are being discharged from the hospital, and if you stay in the hospital after this date, you run the risk of having to pay for the hospital care you receive on and after this date. However, you can appeal any bills for hospital care you receive, using Step 1 of the appeals process described in Section 11.

PART 3. Making complaints if you think your coverage for SNF, home health or certified outpatient rehabilitation facility services is ending too soon.

When you are a patient in a SNF, home health agency, or certified outpatient rehabilitation facility (CORF), you have the right to get all the SNF, home health or CORF care covered by Fallon Senior Plan™ that is necessary to diagnose and treat your illness or injury. The day we end your SNF, home health agency or CORF coverage is based on when your stay is no longer medically necessary. This part of Section 10 explains what to do if you believe that your coverage is ending too soon.

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Information you should receive during your SNF, home health agency or CORF stay

If we decide to end our coverage for your SNF, home, health agency, or CORF services, you will get written notice from your provider at least 2 calendar days in advance of our ending our coverage. You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

Review of the termination of your coverage by the Quality Improvement Organization

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from your provider, you can ask the Quality Improvement Organization (the “QIO”) to review whether our terminating your coverage is medically appropriate.

Getting a QIO review of your coverage

If you want to have the termination of your coverage appealed, you must act quickly to contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- You must be sure to make your request **no later than noon** of the day after you got the written notice from your provider.

If the QIO reviews your case, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

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- If the QIO decides that the decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, home health or CORF charges after the termination date on the advance notice you got from your provider.
- If the QIO agrees with you, then we will continue to cover your SNF, home health or CORF services for as long as medically necessary.

What if you do not ask the QIO for a review by the deadline? You still have another option: asking Fallon Community Health Plan for a “fast appeal” of your discharge

If you do not ask the QIO for a “fast appeal” of your discharge by the deadline, you can ask us for a “fast appeal” of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, home health agency, or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will not cover any care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date

If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, home health or CORF services, and if you stay in the SNF, home health agency or CORF after this date, you run the risk of having to pay for the SNF, home health or CORF care you receive on and after this

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date. However, you can appeal any bills for SNF, home health or CORF care you receive using Step 1 of the appeals process described in Section 11.

PART 4. Making complaints (called “grievances”) about any other type of problem you have with Fallon Community Health Plan, Fallon Senior Plan™ or one of our plan providers

This last part of Section 10 explains how to make complaints about any other type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to coverage or payment for care, and problems about being discharged from the hospital too soon.)

What is included in “all other types of problems”?

Here are some examples of problems that are included in this category of “all other types of problems”:

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you disagree with our decision to not give you a “fast appeal,” or if we take an extension on our initial decision or appeal (initial decisions, appeals, and extensions for initial decisions and appeals are described in Section 11). In these cases, you have the right to ask for a “fast grievance.”
- If you feel that you are being encouraged to leave (disenroll from) Fallon Senior Plan.™
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.

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- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Filing a grievance with Fallon Senior Plan™

If you have a complaint, we encourage you to first call Customer Service at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the grievance procedure.

To use the formal grievance procedure, send your grievance in writing to Fallon Community Health Plan, Consumer Affairs Department, 10 Chestnut St., Worcester, MA 01608. If you prefer, you may call Customer Service at 1-800-868-5200 (TTY/TDD: 1-877-608-7677), Monday through Friday from 8 a.m. to 6 p.m. and ask them to file a grievance for you. Fallon Community Health Plan will respond to you within 25 business days to let you know the way in which we have addressed your issue. In some cases we will need additional time to resolve your concern. In these cases we will inform you of the way in which your grievance is being handled. Whether you use the formal (written) process or the informal (phone) process we keep track of all grievances to report to the Centers for Medicare and Medicaid Services (CMS) and to you, upon your request.

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For quality of care problems, you may also complain to the QIO

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the QIO. See Section 1 for more information about the QIO.

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What is the purpose of this section?

The purpose of this section is to give you more information about a topic that is summarized briefly in the previous section of this booklet (Section 10). Section 10 outlines the six possible steps in the appeals process for making complaints about your coverage or payment for your care. This section goes through the same six steps in more detail. Since Section 10 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, **you should read Section 10 before you read this section.**

A note about terminology. In this Section, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process. For example, we generally say “initial decision” instead of “initial organization determination,” and we generally use the word “fast” rather than “expedited” when referring to decisions that are made more quickly than the standard time frame. Instead of saying “adverse decision,” we may say “deny your request,” or “turn down your appeal.” We use “independent review organization” rather than “independent review entity.”

What are “complaints about your coverage or payment for your care”?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a plan member. This includes payment for care received while a member of the Fallon Senior Plan.[™] Complaints about your coverage or payment for your care include complaints about the following situations:

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- If you are not getting the care you want, and you believe that this care is covered by Fallon Senior Plan[™]
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Fallon Senior Plan[™]
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health
- If you have received care that you believe is covered by Fallon Senior Plan,[™] but we have refused to pay for this care because we say it is not covered

How does the appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one step to the next.** At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.
- **“Initial decision” vs. “making an appeal.”** Step 1 deals with the starting point for the appeals process. The decision made in Step 1 is called an “initial decision” or “organization determination.” If you continue with your complaint by going on to Step 2, it is

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called making an “appeal” or a “request for reconsideration” of our initial decision because you are “appealing” for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involves appealing a decision.

- **Who makes the decision at each step.** In Step 1, you make your request for coverage of care or payment for care directly to us. We review this request, then make an initial decision. If our initial decision turns down your request, you can go on to Step 2, where you “appeal” this initial decision (asking us to reconsider). **After Step 2, your appeal goes outside of Fallon Community Health Plan, where people who are not connected to us conduct the review and make the decision.** To help ensure a fair, impartial decision, those who make the decision about your appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

STEP 1: Fallon Community Health Plan makes an “initial decision” about your medical care, or about paying for care you have already received

What is an “initial decision”?

The “initial decision” made by Fallon Community Health Plan is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This “initial decision” is sometimes called an “organization determination.”) If our initial decision is to deny your request (this is sometimes called an “adverse initial decision”), you can “appeal” the decision by going on to Step 2 (see below). You may also go on to Step 2 if we fail to make a timely “initial decision” on your request.

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- If you ask us to pay for medical care you have already received, this is a request for an “initial decision” about payment for your care. You can call us at 1-800-868-5200 (TTY/TDD: 1-877-608-7677) to get help in making this request.
- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an “initial decision” about whether the treatment you want is covered by Fallon Senior Plan.[™] Depending on the situation, your doctor or other medical provider may make this decision on behalf of Fallon Community Health Plan, or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call us at 1-800-868-5200 (TTY/TDD: 1-877-608-7677) to ask for an initial decision.

When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of Fallon Senior Plan[™] apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by Fallon Senior Plan,[™] including any limitations that may apply to these services. This booklet also lists exclusions (services that are “not covered” by Fallon Senior Plan[™]).

Who may ask for an “initial decision” about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at Fallon Community Health Plan, Customer Service, 10 Chestnut

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Street, Worcester, MA 01608. You can call us at 1-800-868-5200 (TTY/TDD: 1-877-608-7677) to learn how to name your authorized representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact the Executive Office of Elder Affairs Serving Health Information Needs of Elders (SHINE) at 1-800-882-2003 (TDD/TTY: 1-800-872-0166) Monday through Friday, 9 a.m. to 8 p.m.

“Standard decisions” vs. “fast decisions” about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days; see below), or it can be a “fast decision” that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called a 72-hour decision or an “expedited organization determination.”

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: Fallon Community

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Health Plan, Customer Service, 10 Chestnut Street, Worcester, MA 01608.

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a “fast” decision (rather than a “standard” decision) about medical care by calling us at 1-800-868-5200 (for TTY, call 1-877-608-7677). Or, you can deliver a written request to Fallon Community Health Plan, Customer Service, 10 Chestnut Street, Worcester, MA 01608, or fax it to 1-508-755-7393. Be sure to ask for a “fast” or “72-hour” review.

- If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” review, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a “fast grievance.” If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an “initial decision”?

What happens, including how soon we must decide, depends on the type of decision.

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1. For a decision about payment for care you already received.

We have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. (An appeal is also called a reconsideration.) Step 2 tells how to file this appeal.

2. For a standard initial decision about medical care.

We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a “grievance.” Section 10 of this booklet tells how to file a grievance.

We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

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If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. Step 2 tells how to file this appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you do have the right to appeal.

3. For a fast initial decision about medical care.

If you receive a “fast” review, we will give you our decision about your medical care within 72 hours after you or your doctor ask for a “fast” review — sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a “grievance.” Section 10 of this booklet tells how to file a grievance.

We will tell you our decision by phone as soon as we make the decision. Within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a grievance. Section 10 of this booklet tells how to file a grievance.

What happens next if we decide completely in your favor?

If we make an “initial decision” that is completely in your favor, what happens next depends on the situation.

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1. For a decision about payment for care you already received.

We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

2. For a standard decision about medical care.

We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

3. For a fast decision about medical care.

We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you *all* that you requested, you have the right to ask us to reconsider the decision. (See Step 2).

STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an “appeal” or “request for reconsideration.”

Please call us at 1-800-868-5200 (TTY/TDD: 1-877-608-7677) if you need help in filing your appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a “fast” *appeal*. The procedures for deciding on a “standard” or a “fast” appeal are the same as those described for a “standard” or “fast” *initial decision* in Step 1. Please see the discussion in Step 1 under “Do you have a request for medical care that needs to be decided more quickly than the standard time frame?” and “Asking for a fast decision.”

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor’s records or the doctor’s opinion to help support your request. You may need to give the doctor a written request to get information.

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You can give us your additional information in any of the following ways:

- In writing, to Fallon Community Health Plan, Consumer Affairs Department, 10 Chestnut Street, Worcester, MA 01608.
- By fax, at 1-508-755-7393.
- By telephone — if it is a “fast” appeal – at 1-800-868-5200 (TTY/TDD: 1-877-608-7677).

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-868-5200 (TTY/TDD: 1-877-608-7677), Fallon Community Health Plan, Consumer Affairs Department, 10 Chestnut Street, Worcester, MA 01608. We are allowed to charge a fee for copying and sending this information to you.

How do you file your appeal of the initial decision?

The rules about who may file an appeal in Step 2 are the same as the rules about who may ask for an “initial decision” in Step 1. Follow the instructions in Step 1 under “Who may ask for an ‘initial decision’ about medical care or payment?”

Either you, someone you appoint, or your provider may file this appeal.

However, providers who do not have a contract with Fallon Community Health Plan must sign a “waiver of payment” statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

The appeal should be given to us in writing at Fallon Community Health Plan, Consumer Affairs Department, 10 Chestnut Street, Worcester, MA 01608, within 60 calendar days after we notify you of

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the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

You may also send your appeal to your Social Security Administration office or, if you are a railroad retiree, to a Railroad Retirement Board office. Please note that sending your appeal to either of these offices instead of to us will cause a delay when we begin the appeal, since these offices must forward your appeal request to us.

What if you want a “fast” appeal?

The rules about asking for a “fast” appeal in Step 2 are the same as the rules about asking for a “fast” initial decision in Step 1. If you want to ask for a “fast” appeal in Step 2, please follow the instructions in Step 1 under “Asking for a fast decision.”

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. For a decision about payment for care you already received.

After we receive your appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal *automatically* goes to Step 3, where an independent organization will review your case.

2. For a standard decision about medical care.

After we receive your appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

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3. For a fast decision about medical care.

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. For a decision about payment for care you already received.

We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your appeal automatically goes to Step 3, where an independent organization will review your case.

2. For a standard decision about medical care.

We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. For a fast decision about medical care.

We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal — or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

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What happens next if we deny your appeal?

If we deny any part of your appeal in Step 2, then your appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of Fallon Community Health Plan. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the independent review organization that performs the review in Step 3 depends on the type of appeal:

1. *For a decision about payment for care you already received.*

We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your appeal in Step 2.

2. *For a standard decision about medical care.*

We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal in Step 2.

3. *For a fast decision about medical care.*

We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

STEP 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization

What independent review organization does this review?

In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For an *appeal about payment for care*, the independent review organization has up to 60 calendar days to make a decision.
2. For a *standard appeal about medical care*, the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.
3. For a *fast appeal about medical care*, the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

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If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For an appeal about payment for care,*
We must pay within 30 calendar days after receiving the decision.
2. *For a standard appeal about medical care,*
We must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.
3. *For a fast appeal about medical care,*
We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your appeal is \$100 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You have a choice about where you send your written request:

- Directly to the independent review organization that reviewed your appeal in Step 3. They will then send your request along

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with your appeal information to the Administrative Law Judge who will hear your appeal.

- To Fallon Community Health Plan, or to your local Social Security Administration office. If you do this, starting Step 4 will take longer because your request must first be forwarded to the independent review organization that reviewed your appeal in Step 3. The independent review organization will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your appeal for a review by an Administrative Law Judge. During this review, you may present evidence, review the record, and be represented by council. The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than \$100. If the dollar value is less than \$100, you may not appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the date we receive notice of the decision.

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We have the right to appeal this decision by asking for a review by the Departmental Appeals Board (Step 5).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Departmental Appeals Board (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

STEP 5: Your case may be reviewed by a Departmental Appeals Board

This Board will first decide whether to review your case

The Departmental Appeals Board does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or Fallon Community Health Plan may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is \$1,000 or more. If the dollar value is less than \$1,000, you may not appeal any further.

How soon will the Board make a decision?

If the Departmental Appeals Board reviews your case, they will make their decision as soon as possible.

If the Board decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least \$1,000. If the dollar value is less than \$1,000, the Board's decision is final.

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If the Board decides against you

If the amount involved is \$1,000 or more, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than \$1,000, you may not take the appeal any further.

STEP 6: Your case may go to a Federal Court

If the contested amount is \$1,000 or more, you or we may ask a Federal Court Judge to review the case.

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What is “disenrollment”?

“Disenrollment” from Fallon Senior Plan™ means **ending your membership** in Fallon Senior Plan.™ Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave Fallon Senior Plan™ because you have decided that you *want* to leave. You can do this for any reason.
- There are also a few situations where you would be *required* to leave. For example, you would have to leave Fallon Senior Plan™ if you move out of our geographic service area or if Fallon Senior Plan™ leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership officially ends, you must keep getting your Medicare services through Fallon Senior Plan™ or you will have to pay for them yourself

If you leave Fallon Senior Plan,™ it takes some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through Fallon Senior Plan.™ If you get services from doctors or other medical providers who are **not** plan providers before your membership in Fallon Senior Plan™ ends, neither Fallon Community Health Plan nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that

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has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Customer Service at the number on the cover of this booklet to find out if your hospital care will be covered by Fallon Senior Plan.™ If you have any questions about leaving Fallon Senior Plan,™ please call us at Customer Service.

What are your choices for continuing Medicare if you leave Fallon Senior Plan?™

If you leave Fallon Senior Plan,™ one choice for continuing with Medicare is to go to **Original Medicare**. You may also have the choice of joining another **Medicare managed care plan** or a **Medicare Private Fee-for-Service plan** if any of these types of plans are available in your area and they are accepting new members.

- **Original Medicare** is available throughout the country. It is a pay-per-visit or “fee-for-service” health plan that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). Original Medicare is the way most people get their Medicare Part A and Part B health care
- **Medicare Managed Care Plans** (such as HMOs or PPOs) are available in some parts of the country. In HMOs you go to the doctors, hospitals, and other providers *that are part of the plan*. In PPOs, you can usually see any doctor but you may pay more to see doctors, hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescriptions drugs. Fallon Senior Plan™ is a Medicare managed care plan offered by Fallon Community Health Plan.

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- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* Medicare-approved doctor or hospital that accepts the plan's payment. The Private Fee-for-Service plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover. Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance) policies.

When can you change your Medicare choices?

All through the year, everyone with Medicare (including members of Fallon Senior Plan™) is allowed to change from their current way of getting Medicare to one of their other choices. As we have explained above, you have one or more of the following choices about how you get your Medicare coverage. They are:

- **Original Medicare.** This choice is available to you throughout the year.
- **A Medicare Managed Care Plan.** This choice is available to you **if** there are Medicare managed care plans in your area, and **if** they are accepting new members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare+Choice plans must accept new members (unless unusual circumstances apply).
- **A Medicare Private Fee-for-Service plan.** This choice is available to you **if** there are Medicare Private Fee-for-Service plans in your area, and **if** they are accepting new members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Private Fee-for-Service plans must accept new members (unless unusual circumstances apply).

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In most cases, your disenrollment date will be the first day of the month that comes *after* the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: if we receive your request between November 15 and 30, the change will take effect on January 1, unless you specifically ask for a disenrollment date of December 1.

What should you do if you decide to leave Fallon Senior Plan?™

If you want to leave Fallon Senior Plan,™ what you must do to leave depends on whether you want to change to Original Medicare or to one of your other choices. As a Fallon Senior Plan™ member enrolled through an employer group you should contact your former employer for information regarding switching among your Medicare choices.

How to change from Fallon Senior Plan™ to Original Medicare

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from Fallon Senior Plan™ to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact the Executive Office of Elder Affairs (the phone number is in Section 1). You can ask the Executive Office of Elder Affairs about how and when to buy a Medigap policy if you need one. The Executive Office of Elder Affairs can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you have a “**guaranteed issue right**,” this means that the Medigap insurer must sell you a Medigap policy, even if you have health problems. This is a special, temporary right, which means that if you

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decide to change to Original Medicare you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a Medicare managed care plan “trial period” and you change to Original Medicare. Generally, a Medicare managed care plan trial period begins on the date of “first time” enrollment in a Medicare health plan (other than Original Medicare) and ends 12 months later. You may be in a Medicare managed care plan trial period if in the past 12 months you: (1) dropped a Medigap policy to join a Medicare health plan for the first time; or (2) joined a Medicare health plan upon first becoming entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. The Executive Office of Elder Affairs can tell you about other situations where you may have guaranteed issue rights.

If you do buy a Medigap policy, you still have to follow the instructions below for changing from Fallon Senior Plan™ to Original Medicare. (Buying a Medigap policy does not switch you from Fallon Senior Plan™ to Original Medicare. A Medigap sales person or insurance agent cannot cancel your Fallon Senior Plan™ membership and put you in Original Medicare.)

How to change from Fallon Senior Plan™ to Original Medicare

If you decide to change from Fallon Senior Plan™ to Original Medicare, you must tell us (or one of the offices listed below) that you want to leave Fallon Senior Plan.™ You do *not* have to notify Original Medicare, because you will automatically be in Original Medicare when you leave Fallon Senior Plan.™ Here is how it works:

1. First, use any of the following ways to tell us that you want to leave Fallon Senior Plan:™
 - You can write or fax a letter to us or fill out a disenrollment form and send it to Fallon Community Health Plan,

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Customer Service at 10 Chestnut Street, Worcester, MA 01608 or to our fax number at 1-508-755-7393. Be sure to sign and date your letter. To get a disenrollment form, call us at the Customer Service telephone number on the cover of this booklet.

- You can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048.
- You can contact your nearest Social Security office or, if you have Railroad Retirement benefits, you can contact the Railroad Retirement Board office. Section 1 tells you how to contact these offices.

2. We will then send you a letter that tells you when your membership will end. This is your **disenrollment date** – the day you officially leave Fallon Senior Plan.™ In most cases, your disenrollment date will be the first day of the month that comes after the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: the disenrollment date for requests received between November 15 and November 30 are effective on January 1, unless you specifically ask us to disenroll you on December 1. Remember, while you are waiting for your membership to end, you are still a member of Fallon Senior Plan™ and must continue to get your medical care as usual through Fallon Senior Plan.™
3. On your disenrollment date, your membership in Fallon Senior Plan™ ends, and you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave Fallon Senior Plan.™ (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

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How to change from Fallon Senior Plan™ to another Medicare managed care plan or to another Private Fee-for-Service Plan

If you want to change from Fallon Senior Plan™ to a different Medicare managed care plan or to a Private Fee-for-Service plan, here is what to do:

1. Contact the plan you want to join to be sure it is accepting new members.
2. If the plan is accepting new members, apply for membership in the plan. **Once you are enrolled in your new plan, your membership in Fallon Senior Plan™ will *automatically* end.** This means that you do not need to tell us that you are leaving. However, we do encourage you to tell us why you left.
3. Your new plan will tell you in writing the date when your membership in that plan begins, and your membership in Fallon Senior Plan™ will end on that same day (this will be your “disenrollment date”). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through Fallon Senior Plan™ until the date your membership ends.

What happens to you if Fallon Community Health Plan leaves the Medicare program or Fallon Senior Plan™ leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in Fallon Senior Plan™ will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will

Section 12. Leaving Fallon Senior Plan™ and your choices for continuing Medicare after you leave

continue until your membership ends. This means that you must continue to get your medical care in the usual way through Fallon Senior Plan™ until your membership ends.

Your choices will always include Original Medicare. Your choices may also include joining another Medicare managed care plan, or a Private Fee-for-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you may change to another way of getting your Medicare benefits at any time. If you decide to change from Fallon Senior Plan™ to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a “guaranteed issue right” and it is explained earlier in this section under the heading, “Do you need to buy a Medigap (Medicare supplement insurance) policy?”

Fallon Community Health Plan has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Fallon Community Health Plan or CMS can decide to end it. It is also possible for our contract to end at some other time, too. You will get 90 days advance notice in this situation. If the contract is going to end, we will generally tell you 90 days in advance. Your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

You must leave Fallon Senior Plan™ if you move out of the service area or are away from the service area for more than six months in a row

If you plan to move or take a long trip, please call Customer Service at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in plan’s service area. If you

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move permanently out of our service area, or if you are away from our service area for more than six months in a row, you will need to leave (“disenroll” from) Fallon Senior Plan.™ In these situations, if you do not leave on your own, we must end your membership (“disenroll” you). An earlier part of this section tells about the choices you have if you leave Fallon Senior Plan™ and explains how to leave.

Under certain conditions Fallon Community Health Plan can end your membership and make you leave the plan

We *cannot* ask you to leave the plan because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Fallon Senior Plan™ because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line.

We *can* ask you to leave the plan under certain special conditions

- If any of the following situations occur, we will need to end your membership in Fallon Community Health Plan.
- If you move out of our geographic service area or live outside the plan’s service area for more than six months at a time (see Section 2 for information about the plan’s service area).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 8 for information about staying enrolled in Part A and Part B).

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- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in Fallon Senior Plan.™
- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange or provide medical care for you or for others who are members of Fallon Senior Plan.™ We cannot make you leave Fallon Senior Plan™ for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. Before we ask you to leave Fallon Senior Plan™ for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.
- If you do not pay the plan premiums, we will tell you that you have a 90-day grace period during which you can pay the plan premiums before you are required to leave Fallon Senior Plan.™

You have the right to make a complaint if we ask you to leave Fallon Community Health Plan

If we ask you to leave Fallon Senior Plan,™ we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

SECTION 13 Legal Notices

Notice about governing law146

Notice about non-discrimination146

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the commonwealth of Massachusetts may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person’s race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare managed care plans, like Fallon Community Health Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Section 14 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Appeal — Sections 10 and 11 explain about appeals, including the process involved in making an appeal.

Benefit period — For both Fallon Senior Plan™ and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

- You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 7 tells what is meant by skilled care.)
- Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Section 14. Definitions of some words used in this booklet

Centers for Medicare & Medicaid Services (CMS) — The Federal Agency that runs the Medicare program (CMS was formerly known as the Health Care Financing Administration). Section 1 tells how you can contact CMS.

Covered services — The general term we use in this booklet to mean all of the health care services and supplies that are covered by Fallon Senior Plan.™ Covered services are listed in the Benefits Chart in Section 4.

Customer service — A department within Fallon Community Health Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Customer Service.

Disenroll or disenrollment — The process of ending your membership in Fallon Senior Plan.™ Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 12 tells about disenrollment.

Durable medical equipment — is equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Emergency care — Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Evidence of coverage and disclosure information — This document, along with your enrollment form, and any addenda, amendments or riders that we may send you, which explains the covered services, defines our obligations, and explains your rights and responsibilities as a member of the Fallon Senior Plan.™

Section 14. Definitions of some words used in this booklet

Grievance — Section 10 explains about grievances.

Medically necessary — Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare — The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare+Choice Organization — A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare+Choice Organizations can offer one or more Medicare+Choice Plans. Fallon Community Health Plan is a Medicare+Choice Organization.

Medicare+Choice Plan — A benefit package offered by a Medicare+Choice Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare+Choice Organization may offer more than one plan in the same service area. Fallon Senior Plan™ is a Medicare+Choice Plan.

Medicare Cost Plan — A specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all people with Medicare living in the service area covered by the Plan. A company offering a Cost Plan may offer more than one plan in the same service area. Members under this plan may use Original Medicare benefits from any Medicare provider.

Section 14. Definitions of some words used in this booklet

“Medigap” (Medicare supplement insurance) policy — Many people who get their Medicare through Original Medicare buy “Medigap” or Medicare supplement insurance policies to fill “gaps” in Original Medicare coverage.

Member (member of Fallon Senior Plan,TM or “plan member”) — A person with Medicare who is eligible to get covered services, who has enrolled in Fallon Senior Plan,TM and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Non-plan provider or non-plan facility — A provider or facility that we have not arranged with to coordinate or provide covered services to members of Fallon Senior Plan.TM Non-plan providers are providers that are not employed, owned, or operated by Fallon Community Health Plan and are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by Fallon Community Health Plan or Original Medicare.

Original Medicare — A plan that is available everywhere in the United States. Some people call it “traditional Medicare” or “fee-for-service” Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Plan provider — “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**plan providers**” when they are part of Fallon Senior Plan.TM When we say that plan providers are “part of Fallon Senior Plan,TM” this means that we have arranged with them to coordinate or provide covered services to

Section 14. Definitions of some words used in this booklet

members of Fallon Senior Plan.™ Fallon Community Health Plan pays plan providers based on the contracts it has with the providers.

Plan sponsor — the organization that administers your group plan. This is usually your employer.

Primary Care Provider (PCP) — A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Prior authorization — Approval in advance to get services. Some services are covered only if your doctor or other plan provider gets “prior authorization” from Fallon Community Health Plan. Covered services that need prior authorization are marked in the Benefits Chart.

Quality Improvement Organization (QIO) — Groups of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 10 for information about making complaints to the QIO.

Referral — Your PCP’s approval for you to see a certain specialist or to receive certain covered services.

Rehabilitation services — These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 7 for more information.

Service area — Section 2 tells about Fallon Senior Plan's™ service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Urgently needed care — Section 3 explains about urgently needed services. These are different from emergency services.

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